URGENTCARE CHIROPRACTIC®

2675 36th ST NE, STE 401
Calgary, AB T1Y6H6
urgentcarechiropractor.ca
Clinic: 403-769-9111
Fax: 403-769-9110

Physiotherapy Intake Form

Last Name _____ First Name _____ How did you hear about us? _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Emergency Contact _____

Occupation _____ Email (I agree to receive appointment reminders and clinic updates) (OPTIONAL) _____

Birthdate (dd/mm/yr) _____ Gender _____ Marital Status _____ Alberta Health Care Number _____

For your convenience, we can keep a credit card on file:

Number:_____-_____-_____-_____ Expiry:____/____ CCV: _____

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name _____ Group ID/Policy Number _____ Member Number _____

Relationship to Cardholder (self, spouse, child) _____ Name of Cardholder _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

Reason for appointment? _____

When did your condition begin? _____

Have you had X-rays, MRI or other tests? _____

Have you ever tested postive for any blood-borne diseases? (HIV, AIDS, Hepatitis C, etc) _____ Yes No

Are you immunocompromised? Yes No Are you taking blood thinners? Yes No

Is this condition related to: Work? Yes No Has your employer been notified? Yes No

Motor vehicle accident? Yes No Date of injury: _____

Can you perform your daily home activities? Yes Yes, only with help Not at all

Can you perform your daily work activities? All Only some Not at all

Describe your stress level: None Mild Moderate High

Are you, or do plan to become pregnant? Yes No Unknown

Please list any previous surgeries,

Illnesses, injuries (motor vehicle accident):_____

Have you had previous chiropractic care? Yes No Doctor:_____Date:_____

Family doctor name: _____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

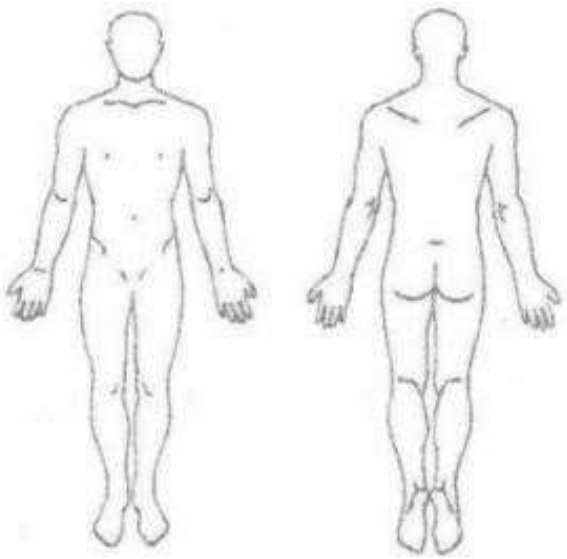
_____

HEALTH HISTORY QUESTIONNAIRE

Have you ever been diagnosed or told you have any of the following?
Please check the correct response:

1.	High blood pressure	Yes	No
2.	Hardening of the arteries (arteriosclerosis)	Yes	No
3.	Diabetes	Yes	No
4.	Tuberculosis	Yes	No
5.	Cancer, where? _____	Yes	No
6.	Heart or blood diseases	Yes	No
7.	Bone spurs on the neck bones (cervical sprain)	Yes	No
8.	Osteoporosis	Yes	No
9.	Whiplash injury (flexion-extension injury, cervical sprain)	Yes	No
10.	Have you ever suffered a stroke?	Yes	No
11.	Were you ever a smoker? From_____To_____	Yes	No
12.	Do you take any medication on a regular basis?	Yes	No
13.	Visual disturbances (blurring, loss, double)	Yes	No
14.	Hearing disturbances (loss, ringing, other noise)	Yes	No
15.	Slurred speech or other speech problems	Yes	No
16.	Difficulty swallowing	Yes	No
17.	Dizziness	Yes	No
18.	Loss of consciousness, even momentary blackouts	Yes	No
19.	Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body	Yes	No
20.	Sudden collapse without loss of consciousness	Yes	No

Indicate the location of your pain by shading the appropriate area:



Indicate the severity of the pain by selecting a number:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Extreme Pain**

Privacy Information

Urgent Care Chiropractic maintains the confidentiality and privacy of individual's personal and health information while collecting, using and disclosing information in compliance with the *Freedom of Information and Protection of Privacy Act and the Health Information Act*

Urgent Care Chiropractic supports the right of individuals or their authorized representatives to access and request corrections to their personal and health information, subject to any specific restrictions in applicable legislation.

We will not collect, use or disclose personal or health information in any manner that is not in accordance with the *Freedom of Information and Protection of Privacy Act, the Health Information Act*, or its established policies.

We may disclose personal or health information for approved purposes as authorized by the *Freedom of Information and Protection of Privacy Act or the Health Information Act*.

Our external web site may collect personal or health information when you voluntarily complete any online application, request form or survey. Personal or health information collected will only be used for the stated purposes. Information is collected pursuant to section 33 of the *Freedom of Information and Protection of Privacy Act* and sections 18–24 of the *Health Information Act*, as applicable.

If you have any questions about our privacy policies and practices, please contact us at 403-769-9111

I, _____ understand that my personal health information is being collected by Urgent Care Chiropractic and that it is protected by *Freedom of Information and Protection of Privacy Act and the Health Information Act*.

Signed: _____

Date:_____

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: Urgent Care Chiropractic
Address: 2675 36th St NE #401
City/Province: Calgary AB
Postal Code: T1Y6H6
Phone Number: 403-769-9111

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: Urgent Care Chiropractic
Address: 2675 36th ST NE #401
City/Province: Calgary AB
Postal Code: T1Y6H6
Phone Number: 403-769-9111

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____

Date: Signature

Print Name:

Electronic Transmission Authorization and Consent Form

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

_____ _____

Date: Signature

Print Name: